Health Care Financing Notes

Medicare: Use of Home Health Services, 1979

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Health Care Financing Notes

The Health Care Financing Administration was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review Organization program, and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 47 million of the nation's aged, disabled, and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

HCFA's Office of Research, Demonstrations, and Statistics (ORDS) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. ORDS also assesses the impact of HCFA programs on health care costs, program expenditures, beneficiary access to services, health care providers, and the health care industry. In addition, ORDS monitors national health care expenditures and prices and provides actuarial analyses on the costs of current HCFA programs as well as the impact of possible legislative or administrative changes in the programs.

The purpose of the ***Health Care Financing Notes*** is to provide the public with descriptive program data or information as soon as it becomes available. Data are presented here in a brief, concise format. Frequently a more comprehensive analysis of the data may be available at a later time in one of the Health Care Financing Administration's other publications.

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Medicare: Use of Home Health Services, 1979

by Charles Helbing

This *Note* presents preliminary data on the use of home health agency (HHA) services by Medicare beneficiaries in 1979.

To qualify for HHA services an enrollee must be under the care of a physician, confined to his home, and in need of intermittent skilled nursing care or physical or speech therapy. Other reimbursable services are occupational therapy, medical social services, and home health aid services. Covered services also include medical supplies (other than drugs or biologicals) and the use of medical appliances. A physician must determine the need for services and set up a patient care plan for home health services. The HHA providing services must be certified for participation in Medicare.

Home health services are furnished under the hospital insurance (HI) and the supplementary medical insurance (SMI) programs of Medicare. Coverage under HI provides for payment of the reasonable cost of up to 100 home health visits after the start of one benefit period and before the start of another.[1] These visits must be furnished in the one-year period following the patient's most recent discharge from a qualifying hospital or a covered skilled nursing facility stay. A qualifying hospital stay is a stay of at least three consecutive days. A plan of treatment must be established by the patient's physician within 14 days after the patient's discharge from a hospital or skilled nursing facility. The services must be necessary for further treatment of the condition for which the patient received services in the hospital or skilled nursing facility.

Coverage under SMI is limited to 100 visits within a calendar year. No prior stay in a hospital or skilled nursing facility is required. Otherwise, the requirements for coverage are the same as those under HI. SMI may be used to cover home health visits after benefits under HI are exhausted. Thus, 100 visits are available under HI for each benefit period but SMI benefits are limited to 100 visits per calendar year.[2]

[1]A benefit period begins with the first day a beneficiary receives covered inpatient hospital services. A benefit period ends when a patient has been out of a hospital (or other facility that provides skilled nursing or rehabilitation services) for 60 consecutive days including the day of discharge. A new benefit period starts the next time the beneficiary enters a hospital. There is no limit to the number of benefit periods a beneficiary may have.

[2]The Omnibus Reconciliation Act of 1980 (P.L. 96-499) removed the limits on the number of HHA visits, eliminated the 3-day prior hospitalization requirements for HHA services under HI, eliminated the application of the SMI deductible to HHA services under SMI, and added occupational therapy as a qualifying service for HHA benefits. These provisions became effective July 1, 1981, and did not affect the provision of services described in this *Note*.

The accompanying tables show: 1) trends in the use of and Medicare reimbursements for home health services; 2) use and reimbursement in 1979 by selected demographic characteristics of the beneficiaries, and 3) use and reimbursements in 1979 by State of residence.

Highlights of the data follow.

Trends In Reimbursements

- Interim reimbursements for home health services under Medicare in 1979 were about $518 million—an increase of 21.4 percent over 1978 (Table 1). Total Medicare reimbursements increased 18.2 percent between 1978 ($23.8 billion) and 1979 ($28.1 billion).
- In 1979, payments to HHAs amounted to slightly more than 1.8 percent of total Medicare payments. This percentage is about the same as that reported for 1978 and slightly higher than percentages in previous years.[3]

Charges and Reimbursements, 1979

- Persons using HHA services incurred charges of $601.4 million, an average of $21,600 per 1,000 enrollees (Table 2).
- The average charge per HHA visit in 1979 was almost $30 compared to $27 in 1978—an increase of about 11 percent.
- Medicare reimbursement for HHA services amounted to $518.2 million, an average of $18,600 per 1,000 enrollees.
- Eighty-six percent of the total HHA charges recorded were reimbursed by the Medicare program.
- About 71 percent of the HHA visits were provided to beneficiaries under the Medicare hospital insurance (HI) program. The remaining 29 percent of the visits were provided under the supplementary medical insurance (SMI) program.
- About 73 percent of the reimbursements for HHA services were paid by the HI program and 27 percent by the SMI program.

Use and Reimbursement by Demographic Characteristics

- Over 19.1 million HHA visits were provided under the Medicare program—an average of 688 visits per 1,000 enrollees.
- Medicare enrollees age 65 and over received 707 HHA visits per 1,000 enrollees and reimbursements of $19,100 per 1,000 enrollees.

[3]In fiscal year 1979, total reimbursements for HHA services by the Medicaid program were $263.6 million, or about 1.3 percent of $20.5 billion reimbursed for all services. For persons 65 and over, Medicaid expended about $17.1 million for HHA services compared to Medicare's $476.4 million. Thus, assuming that these two programs pay for virtually all the HHA services furnished to persons 65 and over, Medicare accounted for almost 97 percent of the total.

- Persons eligible because of disability, including those with end-stage renal disease (ESRD), received 525 HHA visits per 1,000 enrollees, and reimbursements of $14,400 per 1,000 enrollees.
  - Enrollees 65 and over received reimbursements that were, on the average, one-third higher than those received by disabled enrollees.
- Women received 775 HHA visits per 1,000 enrollees, and reimbursements of $20,800 per 1,000 enrollees. Comparable figures for men were 570 visits per 1,000 enrollees, and reimbursements of $15,700 per 1,000 enrollees.
  - Women received reimbursements that were, on the average, one-third higher than those received by men.
- Persons of races other than white received 801 HHA visits per 1,000 enrollees, and reimbursements of $23,200 per 1,000 enrollees. Whites received 691 HHA visits per 1,000 enrollees, and $18,500 in reimbursements per 1,000 enrollees.
  - Non-whites received reimbursements that were, on the average, one-fourth higher than those received by whites.

Use and Charges by Geographic Area

Although this report is based on data that represent about 95 percent of the bills that eventually will be submitted for home health agency services during 1979 (see Sources and Limitations of Data), individual States may vary significantly from this percentage. Therefore, geographic differences are presented only at the region level.

- The Northeast had the highest visit rate among the regions, 980 per 1,000 enrollees. The South had the second highest, 669 per 1,000 enrollees. The North Central region had the lowest visit rate, 533 per 1,000 enrollees (Table 3).
- The West had the highest charge per HHA visit, almost $34 per visit. The Northeast had the lowest average visit charge, about $25 per visit.
- Reimbursements per 1,000 enrollees were highest in the Northeast ($23,700) and lowest in the North Central region ($14,100).

Sources and Limitations of Data

Data published in this report were obtained from billing forms submitted by home health agencies for Medicare beneficiaries receiving reimbursable services in 1979. Figures shown are estimates based on a 40 percent sample of the enrolled population and subject to sampling variability. The sample counts have been inflated to give an estimate of the use of home health services for 1979 based on bills recorded as of July 1980. It is estimated that approximately 95 percent of the bills eventually to be received for home health services were processed by that date. Therefore, the visit and reimbursement rates presented in this *Note* should be viewed as an approximation of the magnitude of differences between population groups with specified characteristics rather than final measures of use. Payments shown are based on interim rates that are adjusted after the end of the accounting year according to reasonable costs of operation.

Standard Error Tables

Tables 4 and 5 show approximate standard errors for estimates presented in this report. The standard error is a measure of sampling variability; the variation occurs by chance because a sample rather than the whole population is used. Approximate methods were used to calculate the standard errors at a reasonable cost. Thus, these tables should be used only as indicators of the order of magnitude of the standard errors for specific estimates.

TABLE 1

Utilization of Home Health Agency Services: Total Medicare Reimbursement, Reimbursement for Home Health Services, and Number of Home Health Visits under Medicare, Calendar Years 1969-79

(in millions)

Year	Total Medicare Reimbursement		Home Health Agency Reimbursement			Home Health Visits	
	Amount	Percent Change	Amount	Percent Change	As Percent of Total Medicare Reimbursement	Number	Percent Change
1969	$ 6,284.0	----	$ 78.1	----	1.24	8.5	----
1970	6,772.4	7.8	61.5	-21.2	.91	6.0	-29.4
1971	7,486.9	10.6	56.8	- 7.7	.76	4.8	-20.5
1972	8,216.1	9.7	65.9	16.1	.80	5.2	9.2
1973	9,637.8	17.3	92.9	40.8	.96	6.4	22.4
1974	11,898.0	23.5	144.3	55.4	1.21	8.2	29.3
1975	14,712.2	23.7	217.0	50.4	1.47	10.9	32.3
1976	17,829.6	21.2	294.6	35.8	1.65	13.5	24.4
1977	20,890.5	17.2	366.5	24.4	1.75	15.6	15.6
1978	23,773.2	13.8	426.9	16.5	1.80	17.1	9.6
1979	28,090.1	18.2	518.2	21.4	1.84	19.2	12.3

Source: Health Care Financing Administration, unpublished utilization statistics. Amounts are for year in which expenses were incurred, based on bills processed through June 1980. Thus, data for most recent years are less complete than data for earlier years.

The amounts reimbursed are based on interim rates which are adjusted after the end of each provider's accounting year on the basis of reasonable costs of operation. Retroactive reimbursements are excluded from the data in these tables.

TABLE 2

Number and Percent Distribution of Home Health Visits and Amount of Charges by Selected Demographic Characteristics, 1979

(numbers and amounts in thousands)

Characteristics	All Beneficiaries				Aged				Disabled			
	Number of Visits	Visit Charges	Total Charges	Total Reimbursement	Number of Visits	Visit Charges	Total Charges	Total Reimbursement	Number of Visits	Visit Charges	Total Charges	Total Reimbursement
Total	19,159	$572,223	$601,439	$518,248	17,632	$526,559	$552,819	$476,363	1,527	$45,664	$48,620	$41,885
Sex:												
Male	6,782	205,085	217,644	186,577	6,084	184,180	195,130	167,350	698	20,904	22,514	19,227
Female	12,377	367,138	383,795	331,671	11,548	342,379	357,689	309,013	829	24,760	26,106	22,658
Race:												
White	16,888	498,222	523,312	452,141	15,625	461,150	483,764	418,027	1,264	37,072	39,547	34,114
All Other	2,135	69,194	72,926	61,731	1,887	61,130	64,428	54,461	248	8,063	8,499	7,270
Unknown	135	4,807	5,201	4,376	120	4,279	4,627	3,875	15	529	574	501
Type of Coverage:												
Hospital Insurance	13,681	412,722	433,810	377,616	12,636	381,010	399,968	348,288	1,045	31,712	33,843	29,327
Medical Insurance	5,478	159,501	167,629	140,632	4,996	145,549	152,851	128,075	482	13,952	14,777	12,558
	Percent Distribution											
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Sex:												
Male	35.4	35.8	36.2	36.0	34.5	35.0	35.3	35.1	45.7	45.8	46.3	45.9
Female	64.6	64.2	63.8	64.0	65.5	65.0	64.7	64.9	54.3	54.2	53.7	54.1
Race:												
White	88.2	87.1	87.0	87.2	88.6	87.6	87.5	87.8	82.8	81.2	81.3	81.4
All Other	11.1	12.1	12.1	11.9	10.7	11.6	11.7	11.4	16.2	17.7	17.5	17.4
Unknown	.7	.8	.9	.9	.7	.8	.8	.8	1.0	1.1	1.2	1.2
Type of Coverage:												
Hospital Insurance	71.4	72.1	72.1	72.9	71.7	72.4	72.4	73.1	68.4	69.4	69.6	70.0
Medical Insurance	28.6	27.9	27.9	27.1	28.3	27.6	27.6	26.9	31.6	30.6	30.4	30.0
	Per 1,000 Enrollees											
Total	688	$20,500	$21,600	$18,600	707	$21,100	$22,200	$19,100	525	$15,700	$16,700	$14,400
Sex:												
Male	570	17,200	18,300	15,700	605	18,300	19,400	16,600	380	11,400	12,300	10,500
Female	775	23,000	24,000	20,800	775	23,000	24,000	20,700	773	23,100	24,300	21,100
Race:												
White	691	20,400	21,400	18,500	708	20,900	21,900	19,000	529	15,500	16,600	14,300
All Other	801	26,000	27,400	23,200	860	27,900	29,400	24,800	527	17,100	18,000	15,400
Unknown	179	6,400	6,900	5,800	171	6,100	6,600	5,500	288	10,200	11,000	9,600
Type of Coverage:												
Hospital Insurance	498	15,000	15,800	13,800	515	15,500	16,300	14,200	359	10,900	11,600	10,100
Medical Insurance	205	6,000	6,300	5,300	207	6,000	6,300	5,300	181	5,200	5,600	4,700

TABLE 3

Number of Visits and Amount of Charges, by Geographic Area, 1979

(numbers and amounts in thousands)

Geographic Area	Number of Visits	Visit Charges	Charge per Visit	Total Charges	Total Reim-bursement
All Areas	19,159	$572,223	$29.87	$601,439	$518,248
United States	18,768	554,955	29.57	581,603	505,240
Northeast	6,402	162,903	25.44	169,737	154,909
North Central	3,832	113,198	29.54	116,874	101,248
South	6,017	193,870	32.22	206,263	168,860
West	2,517	84,984	33.76	88,729	80,223
New England	1,991	40,974	20.58	41,719	39,901
Connecticut	545	12,001	22.03	12,134	11,636
Maine	139	3,157	22.79	3,227	3,038
Massachusetts	968	19,190	19.82	19,556	18,579
New Hampshire	98	1,751	17.78	1,760	1,702
Rhode Island	145	3,019	20.89	3,172	3,131
Vermont	96	1,857	19.28	1,870	1,815
Middle Atlantic	4,411	121,929	27.64	128,019	115,007
New Jersey	1,008	26,107	25.89	27,057	26,413
New York	1,607	50,285	31.28	53,350	47,464
Pennsylvania	1,796	45,537	25.36	47,611	41,131
East North Central	2,535	81,810	32.28	83,438	71,929
Illinois	980	36,687	37.44	37,258	28,970
Indiana	182	4,192	23.07	4,448	4,194
Michigan	448	16,655	37.18	16,816	15,008
Ohio	645	17,336	26.87	17,800	17,115
Wisconsin	280	6,940	24.78	7,116	6,642
West North Central	1,297	31,389	24.20	33,436	29,319
Iowa	148	2,178	14.68	2,215	2,109
Kansas	124	2,699	21.71	2,748	2,456
Minnesota	162	4,297	26.60	4,431	4,147
Missouri	731	19,344	26.46	20,900	17,655
Nebraska	75	1,880	25.14	2,128	2,022
North Dakota	21	401	19.10	416	365
South Dakota	36	588	16.31	598	566
South Atlantic	3,265	109,020	33.39	113,196	93,682
Delaware	66	1,381	20.81	1,440	1,261
Dist. Of Columbia	50	1,519	30.13	1,522	1,413
Florida	1,803	64,614	35.84	66,724	53,324
Georgia	322	12,828	39.85	13,524	9,719
Maryland	229	7,162	31.21	7,337	7,047
North Carolina	331	7,894	23.81	8,391	8,097
South Carolina	202	6,716	33.28	7,102	6,384
Virginia	123	3,416	27.78	3,441	3,277
West Virginia	137	3,490	25.40	3,715	3,160
East South Central	1,350	40,552	30.04	45,288	35,983
Alabama	371	10,356	27.92	11,075	9,558
Kentucky	162	4,871	29.99	5,506	5,025
Mississippi	461	14,066	30.53	16,013	11,308
Tennessee	356	11,259	31.63	12,694	10,092
West South Central	1,402	44,299	31.59	47,779	39,194
Arkansas	67	2,193	32.62	2,326	2,106
Louisiana	392	10,991	28.01	12,686	9,981
Oklahoma	82	2,762	33.62	2,856	2,436
Texas	861	28,352	32.94	29,910	24,670
Mountain	529	14,013	26.50	14,874	13,709
Arizona	70	2,058	29.30	2,274	2,015
Colorado	172	5,045	29.33	5,085	4,710
Idaho	70	1,684	24.13	2,003	1,804
Montana	30	729	24.08	787	727
Nevada	33	815	24.95	841	829
New Mexico	80	2,224	27.72	2,340	2,157
Utah	48	907	19.06	968	938
Wyoming	26	549	21.20	576	529
Pacific	1,988	70,971	35.69	73,855	66,514
Alaska	2	88	36.73	90	88
California	1,515	55,191	36.44	57,174	51,168
Hawaii	43	1,404	32.92	1,563	1,532
Oregon	176	5,983	33.91	6,418	6,022
Washington	252	8,305	32.94	8,610	7,704
Outlying Areas 1/	390	17,268	44.22	19,837	13,009

1/ Includes Puerto Rico, Virgin Islands, Guam, Other Areas, and Residence Unknown

TABLE 4
Approximate Standard Error of Number of Visits

Estimated Number of Visits	Standard Error of Estimate
5,000	890
10,000	1,300
50,000	3,000
100,000	4,300
500,000	10,000
1,000,000	15,000
4,000,000	31,000
8,000,000	38,000

TABLE 5
Approximate Standard Error of Amount of Total Charges, Visit Charges, or Reimbursement

Estimate of Charges	Standard Error of Estimate
$ 50,000	$ 10,000
100,000	14,000
500,000	35,000
1,000,000	53,000
10,000,000	220,000
30,000,000	470,000
100,000,000	710,000
150,000,000	720,000

Health Care Financing Notes

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